Fax Transmittal Sheet

Nevada Medicaid and Nevada Check Up – Outpatient Mental Health FA-11 Authorization Request

To:	HP Enterprise Services NV MH Outpatient Program
Fax Number:	(866) 480-9903
Phone Number:	(800) 525-2395
From:	
Fax Number:	
Phone Number:	
Date:	
Number of Pages: (including this cover page)	

☐ **Urgent** ☐ **For Approval** ☐ **Please Comment** ☐ **Please Reply**

Comments

Outpatient Mental Health

Purpose: To request outpatient mental health services. Outpatient services may also be requested on form FA-11A either in combination with rehabilitation services or alone.

Fax this request to: (866) 480-9903 **Questions? Call:** (800) 525-2395

Request Date:	Recipient Name:
REQUEST TYPE: ☐ Initial Prior Authorization – Start date of services: _____ ☐ Concurrent Authorization ☐ Unscheduled Revision ☐ Reconsideration ☐ Retrospective Authorization – Date of Eligibility Decision: _____	

I. REQUESTING PROVIDER

Name:		Credentials:
NPI:	Phone:	Fax:
Requesting provider's group NPI:		

II. RECIPIENT

Name:	DOB:
Recipient ID:	Age:
Recipient's Living Arrangements (e.g., group home, foster home, parents):	
Is the recipient in State custody? ☐ Yes ☐ No ☐ Unknown	Date recipient went into State custody:

III. RESPONSIBLE PARTY

Organization/Legally Responsible Adult Name:	Phone:
Address *(City, State, Zip)*:	
Relationship to Recipient:	

IV. MULTIAXIAL DIAGNOSIS

DSM Diagnosis		
Axis I	Primary Code:	Narrative:
	Secondary Code:	Narrative:
	Tertiary Code:	Narrative:
Axis II		
Axis III		
Axis IV	*(Check all items that present a problem for the recipient.)* ☐ Primary support group ☐ Social environment ☐ Education ☐ Occupation ☐ Housing ☐ Economic ☐ Access to healthcare ☐ Legal ☐ Other *(specify)*: _____	
Axis V	Current GAF:	Highest GAF in the last year:

DC: 0-3 Diagnosis Code and Descriptor *(if applicable)*		
Axis I	Primary code:	Narrative:
	Primary code:	Narrative:
	Primary code:	Narrative:
	ICD-9/DSM:	
Axis II	PIRGAS:	
Axis III		

Outpatient Mental Health

Request Date:		Recipient Name:	
Axis IV			
Axis V	**Rating**	**Capacity**	**Typical Age of Onset**
		Attention and regulation	0-3 months
		Forming relationships/mutual agreement	3-6 months
		Intentional two-way communication	4-10 months
		Complex gestures and problem-solving	10-18 months
		Use of symbols to express thoughts/feelings	18-30 months
		Connecting symbols logically/abstract thinking	30-48 months
Clinical Assessor Name and Credentials:			Date:

VI. ASSESSMENT SCORE

☐ CASII	Score:	Level:	Date:
☐ LOCUS	Score:	Level:	Date:

☐ ECSII or Other Assessment *(specify)*:	Score:	Level:	Date:
Clinical Assessor Name:		Credentials:	

VII. CURRENT MEDICATIONS

List current medications/dosage. Attach additional sheets if needed to fully document all medications.

Medication Name	Dosage/Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	

CURRENT FUNCTIONING AND RISK FACTORS

Describe functioning in various areas (e.g., social, school, relationships) and note any indicators of heightened risk (e.g., abuse, suicide/homicide ideation/attempts, psychosis, medical conditions).

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CURRENT SYMPTOMS

- ☐ School Performance/Underachieving
- ☐ Job Performance
- ☐ Interpersonal/Social Conflicts
- ☐ Family Conflicts
- ☐ Financial Stress/Inability to Manage Finances
- ☐ Sexual Performance Problems
- ☐ Sexual Promiscuity
- ☐ Sleep Disturbance
- ☐ Physical Health Problems
- ☐ Appetite Disturbance
- ☐ Overeating/Increased Appetite ☐ Poor Appetite
- ☐ Other Symptoms *(please specify)*:
- ☐ Depression
- ☐ Hopeless/Helpless
- ☐ Low Energy/Motivation
- ☐ Isolating
- ☐ Anxiety
- ☐ Anger Control/Aggression
- ☐ Problems Concentrating
- ☐ Hyperactivity
- ☐ Psychotic Symptoms

Weight Loss/Gain in Last 3 Months: _____ pounds

SIGNIFICANT LIFE EVENTS AND FAMILY HISTORY

Provide significant life events that relate to the recipient's Axis I diagnosis and/or that brought the recipient to treatment, e.g., pertinent family information, developmental history, medical issues, sexual history, substance abuse and legal history.

PREVIOUS TREATMENT

Provide dates of previous treatment.

- ☐ Inpatient Psychiatric Dates:
- ☐ RTC Dates:
- ☐ Outpatient Mental Health Dates:
- ☐ Substance Abuse Dates:

Outpatient Mental Health

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TREATMENT PLAN AND RATIONALE / DISCHARGE PLAN *For each problem/behavior identify long and short term goals, strength and psychosocial support progress or regression during the last authorized period.*

REQUESTED AND APPROVED TREATMENT *The "Requester" named below will be deemed the point of contact for this authorization request and is responsible for dissemination of all information regarding this request.*

Requester Name:	Requester NPI:
Requester Fax:	

Enter the requested code below. "Req." is an abbreviation for Requested Service. Enter your requested services on this row. In the Total Units column, enter the total units for this code for this request. "App." is an abbreviation for Approved Service. HP Enterprise Services will enter approved service information on this line after receiving your completed request.

	Code		Start Date and End Date	Total Units	Authorization Number
1		**Req.**			
		App.			
2		**Req.**			
		App.			
3		**Req.**			
		App.			
4		**Req.**			
		App.			
5		**Req.**			
		App.			
6		**Req.**			
		App.			

Requester's Signature:	**Date:**
Date Received:	**Date Deferred to MD:**
Date of Determination:	**Reviewer Initials:**